CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AN
Hearing dates:	20 and 21 April 2026
Date of findings:	1 June 2026
Place of findings:	Coroners Court, Lidcombe
Findings of:	Judge Hosking, Deputy State Coroner
Catchwords:	Memory lapses during routine activities with fatal outcomes; the dangers of children being left in motor vehicles.
File number:	2023/00036572
Representation:	Counsel assisting the inquest: William de Mars of Counsel instructed by Jessica Best, Crown Solicitor's Office AN's family: Sarah Woodland of Counsel
Publication orders:	Non-publication and pseudonym orders apply to the evidence in this inquest. A copy of the orders made by Judge Hosking are available upon request from the Court Registry.
Findings:	AN died on 2 February 2023 at Glenfield from hyperthermia due to environmental heat exposure due to vehicular entrapment. AN was unintentionally left in the vehicle because of memory failure.

Recommendations:

1 I direct that copies of the brief of evidence, the transcript of evidence and these findings be sent to:

(1) The Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts
(2) The NSW Minister for Education
(3) The NSW Department of Education
(4) The NSW Early Learning Commission
(5) The NSW Minister for Health

(6) The NSW Ministry of Health, and
(7) The executive officer, Kidsafe NSW.

2 I recommend to the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts:

(1) that it considers collating and including data and statistics in its National Road Safety Data Hub, or other appropriate public database, in relation to death and injury occurring to children because of:

(a) being unintentionally left in a motor vehicle
(b) being intentionally left in a motor vehicle, and
(c) children independently gaining access to a motor vehicle.

3 I recommend to the NSW Minister for Education, the Department of Education and the NSW Early Learning Commission:

(1) that they expand current and future public facing awareness campaigns relating to children being left in motor vehicles to cover circumstances that involve a child being unintentionally left in a motor vehicle including promotion of the following messages:

(a) how easily and readily memory failures can occur
(b) that the same type of memory failure that most people experience in relation to mundane matters (such as forgetting keys, or driving in a wrong direction out of habit) can easily occur in relation to a more critical matter such as dropping one's young child off at childcare
(c) that parents of young children as a group are particularly susceptible to this form of memory failure, and the reasons for this, and
(d) that parents and caregivers can adopt 'cues' to remember the presence of their child (such as placement of child's essential items on front passenger seat, placement of a valuable item for the parent or caregiver in the back of the vehicle near the child seat, ensuring there is a system in place for notification by childcare if their child unexpectedly does not attend).

(2) that they consider, in the context of the NQF and having regard to the evidence and findings in this inquest and the inquest into the death of OVA, introducing a system requiring the mandatory notification of a parent or caregiver by childcare services of unexpected absences of children.

4 I recommend to the NSW Minister for Health and NSW Ministry of Health:

(1) that they consider including in the 'Blue Book' and other material distributed to parents and caregivers of young children, and in public education activities that involve engaging with new parents and caregivers, material that promotes the following messages:

(a) how easily and readily memory failures can occur
(b) that the same type of memory failure that most people experience in relation to mundane matters (such as forgetting keys, or driving in the wrong direction out of habit) can easily occur in relation to a more critical matter such as dropping one's young child off at childcare
(c) that parents of young children as a group are particularly susceptible to this form of memory failure, and the reasons for this

(d) that parents and caregivers can adopt as ‘cues’ to remember the presence of their child (such as placement of child’s essential items on the front passenger seat, placement of a valuable item for the parent or caregiver in the back of the vehicle near the child seat, ensuring there is a system in place for notification by childcare if their child unexpectedly does not attend).

Introduction 5
The role of the coroner 5
The issues examined in the inquest 5
The evidence 6
Findings and recommendations 7
Background 7
AN 7
2 February 2023 7
Date, place and cause of death 8
Dr Irvine, post-mortem report dated 5 January 2024 8
Circumstances (manner) of AN's death 9
AN's father 9
Professor Muireann Irish, report dated 12 March 2026 9
Is it necessary or desirable to make recommendations 12
Data collection and education 12
Christine Erskine, Executive Officer, Kidsafe NSW 12
Recommendations 14
Technology 17
Australian Standards 17
Mark Terrell, Chief Technical Officer, ANCAP Safety 17
After market devices 18
Recommendations 18
Childcare provider notifications 19
Recommendation 21
Concluding remarks 22
Statutory findings required by s 81(1) 22

Introduction

1 On 2 February 2023, 3 year old AN died tragically after being unintentionally left in the family motor vehicle for an extended period. His death continues to be mourned by his family and community who loved and cherished him.

2 An inquest into AN's death was held at the Coroners Court at Lidcombe on 20 and 21 April 2026 concurrently with the inquest into the death of OVA[1].

3 These are my findings following the inquest into AN's death.

The role of the coroner

4 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death[2]. A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future[3].

The issues examined in the inquest

5 The issues identified in the coronial investigation to be examined at the inquest are outlined below.

(1) The formal findings that should be made pursuant to s 81 of the Act in particular, in relation to the circumstances surrounding AN's death (i.e. manner of death):

(a) what role, if any, did memory failure play?

(b) if memory failure did play a role, how does cognitive neuroscience help to explain how such memory failure can occur?

---

[1] OVA died on 4 February 2025 in similar circumstances.
[2] S 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[3] S 82 of the Act.

(2) Whether any recommendations are necessary or desirable in connection with AN's death, including consideration of:

(a) what preventive measures can be taken to reduce the likelihood of deaths such as these occurring, including in relation to:

(i) practices that drivers are encouraged to habitually adopt when undertaking a vehicle journey with a young child

(ii) notifications of non-attendance by childcare providers

(iii) warning systems built into motor vehicles or other forms of warning technology.

(b) the current state of any regulation by authorities concerning relevant warning systems or technology, and notification of non-attendance at childcare.

(c) the extent to which public awareness campaigns in New South Wales address the risk of 'forgetting' leading to caregivers unintentionally leaving a child unattended in their vehicle.

The evidence

6 A 3-volume brief of evidence was tendered to the Court and oral evidence was adduced at the inquest from:

(1) Professor Muireann Irish, PhD, FRSN, FASSA, NHMRC Professorial Fellow, School of Psychology and Brain and Mind Centre, The University of Sydney

(2) Christine Erskine, Executive Officer, Kidsafe NSW

(3) Mark Terrell, Chief Technical Officer, ANCAP[4].

Findings and recommendations

7 See pages 1-3 for a summary of the findings and recommendations made in this inquest.

Background

8 I have drawn from submissions by Counsel Assisting in relation to non-contentious factual matters and issues. I am grateful for this assistance.

AN

9 AN was born on 19 July 2019 to loving parents and he was welcomed by his big brother (**ANB**). The family lived in Glenfield, NSW. AN's childhood was joyful. He was happy and wanted those around him to be happy. His father described him as a 'magnetic force' that could attract people quickly. His uncle described him as 'a hybrid car' because of his unique, high-energy personality – his movements were quiet but unpredictable.

10 In 2023, AN was attending family childcare 5 days a week and ANB was at primary school. AN's mother worked out of the home and his father, post covid, would work from home and sometimes in his office in the Sydney CBD. AN's father was usually responsible for dropping his sons off at school and childcare as his mother left the home earlier for work.

2 February 2023

11 The family had a guest the night before, AN went to bed later than usual at around 11pm. AN's father went to bed at about 12.45am on 2 February 2023.

12 AN's father woke around 8am on 2 February 2023 and woke ANB. AN's mother left for work while AN was still asleep.

[4] Australasia New Car Assessment Program.

13 AN woke up, came downstairs and went back to sleep on the lounge.

14 At around 9am, AN’s father carried AN to the car and then drove with AN and ANB to take ANB to school.

15 When AN’s father left the school, his petrol warning light came on in his car. He then drove to a petrol station and put petrol in the vehicle at 9.11am.

16 Significantly, the direction of travel as he left the petrol station was the same whether he was driving to AN’s childcare or driving home.

17 AN’s father then left the petrol station and, instead of driving AN to childcare, he drove straight home. AN was silent in the car on the way home, likely asleep.

18 At around 9.20am, AN’s father unintentionally, because of a memory lapse (detailed further below), went inside the house and commenced his workday leaving AN in the car.

19 Temperatures on 2 February 2023 reached a maximum of 31°C.

20 At around 2.35pm AN’s father returned to the car and drove to ANB’s school. He picked up ANB at around 2.54pm, they went to a nearby shop and then returned to the car. When AN’s father opened the back door of the car for ANB at 2.54pm, he saw AN in the vehicle. He screamed for help, retrieved AN from the vehicle, commenced CPR and splashed water on AN. An ambulance was called. AN was pronounced deceased at the scene by attending paramedics at 3.18pm.

Date, place and cause of death

Dr Irvine, post-mortem report dated 5 January 2024

21 Dr Irvine conducted a forensic post-mortem examination on 6 February 2023.

22 Dr Irvine reported that CCTV footage showed that AN had established rigor mortis when he was retrieved from the vehicle by his father indicating he was deceased when he was discovered.

23 AN's toxicology analysis indicated no evidence of alcohol or drugs.

24 An examination of AN's brain showed no specific acute cause of death or unexpected underlying condition.

25 Dr Irvine concluded that AN died from hyperthermia due to environmental heat exposure due to vehicular entrapment.

26 Consistent with Dr Irvine's opinion, I find that AN died on 2 February 2023 between 9.20am and 2.54pm from hyperthermia due to environmental heat exposure due to vehicular entrapment.

27 In relation to the place of AN's death, it appears likely that he was deceased when his father returned to the vehicle at 2.35pm. However, absent any specific evidence in that regard, I will make a general finding that he died in Glenfield which encompasses the family home and the route to ANB's school.

Circumstances (manner) of AN's death

AN's father

28 In his ERISP, AN's father recalled:

> …I thought I'd dropped him. I didn't, it's like a subconsciously that's what I do every day, so I, I was not thinking about it at all. So I went, I went home, I opened my computer, started working…
>
> …we opened the door and I, I couldn't believe my eye that he's just sitting on his car seat. I don't know I did it…

Professor Muireann Irish, report dated 12 March 2026

29 Professor Irish opined that:

> …Memory relies upon multiple underlying processes, some of which are automatic and some of which require conscious attention.

…The human brain is optimised for efficiency. This is reflected in our capacity for habitual processing, which enables us to complete routine activities (e.g. commuting, daily self-care routine) with minimal conscious effort…these cognitive 'shortcuts' are crucial for everyday behaviour. We do not need to pay conscious attention to every decision or action that we take, rather we can offload routine tasks that rarely deviate from the script to reduce mental load. Automatic processes should not be viewed as negative. They are highly adaptive mechanisms that allow the brain to conserve attention resources, speed up performance, and complete routine everyday tasks efficiently…They can be likened to being on 'autopilot' enabling us to conserve attention for more cognitively demanding tasks.

In contrast, controlled processes are conscious, deliberate and effortful, for example paying attention the very first time you drive a new route to work or remembering to do something in the future (prospective memory).

Prospective memory is a future-oriented expression of memory that enables us to remember to perform intended actions in the future, for example remembering to pick up milk on the way home…. Prospective memory is inherently complex as it requires us not only to remember to perform an intended action, but to do so at the right time or in the right context, often while other tasks are ongoing… Failures in these types of memory are common and well-documented in cognitive psychology.

…Having encoded the intention, the person typically engages in other tasks while waiting for the correct moment to act. The critical point here is that the intention is not held in conscious awareness but instead relies on the presence of a cue from the external environment to trigger retrieval of the intention. These cues could come in the form of a location/object, an event, or a time.

…Although controlled and automatic processes operate effectively in tandem, memory lapses can and do occur in daily life. When memory fails, this reflects the breakdown of one or more component processes in an otherwise normal cognitive architecture, which has evolved to prioritise efficiency and predictability.

In a brain optimised for efficiency, human attention is limited…Under conditions of high attentional load…the probability that a cue will trigger the intended action is reduced…even strong intentions may fail under conditions of high attentional load.

Well-learned habitual and routine behaviours are powerful shortcuts to optimise behaviour, particularly in familiar environments. Their automaticity, however, can sometimes override intended actions… the same cognitive shortcuts that enable us to offload mental effort and reduce attentional load, can become proceduralised to the point that they occur relatively automatically. This can be the case even when intentions are well-formed and attention is in place.

In the case of prospective memory, the intention may still exist, but the intended action may be blocked or delayed by execution of the automatic routine.

30 Professor Irish also reported that:

(1) chronic stress, poor sleep quality and fatigue can all contribute to prospective memory performance; and

(2) the human memory is reconstructive, when a sequence of events unfolds in line with a daily routine for example, the brain may conserve energy by filling in the details using memory reconstruction.

31 In this case, the prospective memory was the intention to drop AN off at childcare. Consistent with Professor Irish's opinion, I accept that while the prospective memory was formed, AN was not dropped off at childcare in circumstances where:

(1) the ordinary routine of travel from ANB's school to childcare was interrupted by the detour to the petrol station

(2) the direction of travel from the petrol station, being the same as if going to AN's childcare or home, combined with the general familiarity and routine nature of the route, triggered the execution of AN's father's automatic routine being his return home

(3) there were no other cues triggering the prospective memory such as AN making noise.

32 I further accept that on his return home, AN's father did not remember that he had not dropped AN off at childcare as it was such a routine task, his reconstructive memory was such that he believed that is what he had done.

33 In relation to AN's manner of death, I find that AN was left in the vehicle unintentionally because of a memory lapse.

34 I have purposely not used the phrase 'forgotten baby syndrome' in these findings. Professor Irish's evidence was that pathologising the circumstances is not helpful. It fails to highlight that circumstances of memory lapse or memory failure can occur to anyone with ordinary cognitive function in relation to both

ordinary matters, such as forgetting milk, and matters with catastrophic consequences.

Is it necessary or desirable to make recommendations

35 The inquest focused on 4 areas in which recommendations for death prevention could be made:

(1) data collection

(2) education

(3) technology

(4) childcare provider notifications.

Data collection and education

Christine Erskine, Executive Officer, Kidsafe NSW

36 Generally, there are three situations in which a child can become trapped in a motor vehicle:

(1) because of a conscious decision to leave the child in the vehicle – usually for a brief period (**conscious decision**)

(2) because of a memory lapse in circumstances described above by Professor Irish (**memory lapse**), or

(3) because the child entered an unlocked vehicle and then cannot get out.

37 Education programs focused on highlighting the dangers of leaving a child in a car for even a brief period do not impact a memory lapse situation, in which case the child is not in the car because of a conscious intention to 'skirt the risk.'

38 In his family statement, AN's father stated that he cannot believe what happened, and that it does not make sense how it could happen to him, an

obviously loving father. The fact that the most diligent parent could suffer a memory lapse, despite their awareness of the dangers of a child being left in the car, is a separate and distinct issue requiring education.

39 Ms Erskine confirmed that the focus of education programs to reduce the risk of a child being left in a vehicle because of a memory lapse needs to highlight the fallibility of memory, particularly parents or caregivers who may be suffering from fatigue, poor sleep and stress.

40 Ms Erskine outlined multiple education campaigns around demonstrating the dangers of leaving children in cars. These campaigns are usually directed at the conscious decision to leave a child in a car. The education around the issue of memory lapse has been far more limited in NSW and more broadly in Australia[5].

41 Ms Erskine also indicated that Australia lacks comprehensive national data on serious injury and child deaths in hot cars. She reported that:

(1) a source identified as ‘NSW Government – Education, 2024’, indicated that 6 children died in NSW between 2018 and 2023 from being left in cars; and

(2) NRMA recorded 1,900 ‘lock in’ call outs were received in 2024 including many involving children

42 By comparison, the USA maintains a centralised database on paediatric heatstroke deaths. The USA has documented over 1,000 such deaths since 1998 and they have also recorded that 29 children died from vehicular heatstroke in 2023.

[5] Some programs identified include elements of the NSW Government’s ‘Look Before You Lock’ Program (largely directed at the transportation responsibilities of early childhood care providers rather than parents); The Sydney Children’s Hospital Network car-key tag as a reminder to check for your baby when taking the keys out of the ignition.

43 According to Ms Erskine, the gap in data collection in Australia makes it challenging to assess the full scale of the issue and to implement evidence-based, targeted interventions.

44 Ms Erskine opined that a co-ordinated national public health campaign combined with improved data collection and policy development is essential to death prevention.

45 Ms Erskine recommended:

(1) the establishment of a national injury database

(2) advocating for ongoing research and funding

(3) strengthening of public awareness campaigns

(4) collaboration with international experts

(5) promotion of enhanced vehicle technology.

Recommendations

46 To combat the deficiencies in data collection and education I make the recommendations that follow.

I direct that a copy of the brief of evidence, the transcript of evidence and these findings be sent to the Commonwealth Department of Infrastructure, Transport, Regional Development, Communications, Sports and the Arts and that they:

(1) consider collating and including data and statistics in its National Road Safety Data Hub, or other appropriate public database, in relation to death and injury occurring to children because of:

(a) being unintentionally left in a motor vehicle

(b) being intentionally left in a motor vehicle, and

(c) children independently gaining access to a motor vehicle.

I direct that copies of the brief of evidence, transcript of evidence and these findings be sent to the NSW Minister for Education, the Department of Education (**DoE**) and the NSW Early Learning Commission and that they:

(1) expand their current and future public facing awareness campaigns relating to children being left in motor vehicles to cover circumstances that involve a child being unintentionally left in a motor vehicle including promotion of the following messages:

(a) how easily and readily memory failures can occur

(b) that the same type of memory failure that most people experience in relation to mundane matters (such as forgetting keys, or driving in the wrong direction out of habit) can easily occur in relation to a more critical matter such as dropping one's young child off at childcare

(c) that parents of young children as a group are particularly susceptible to this form of memory failure, and the reasons for this, and

(d) that parents and caregivers can adopt 'cues' to remember the presence of their child (such as placement of child's essential items on the front passenger seat, placement of a valuable item for the parent or caregiver in the back of the vehicle near the child seat, ensuring there is a system in place for notification by childcare if their child unexpectedly does not attend).

I direct that copies of the brief of evidence, transcript of evidence and these findings be sent to the NSW Minister for Health and NSW Ministry of Health and that they:

(1) consider including in the 'Blue Book' and other material distributed to parents and caregivers of young children, and in public education activities that involve engaging with new parents and caregivers, material that promotes the following messages:

(a) how easily and readily memory failures can occur

(b) that the same type of memory failure that most people experience in relation to mundane matters (such as forgetting keys, or driving in the wrong direction out of habit) can easily occur in relation to a more critical matter such as dropping one's young child off at childcare

(c) that parents of young children as a group are particularly susceptible to this form of memory failure, and the reasons for this

(d) that parents and caregivers can adopt as 'cues' to remember the presence of their child (such as placement of child's essential items on the front passenger seat, placement of a valuable item for the parent or caregiver in the back of the vehicle near the child seat, ensuring there is a system in place for notification by childcare if their child unexpectedly does not attend).

Technology

Australian Standards

47 Section 13, 'Warning devices for child restraint occupants left in vehicles' in *AS 8005:2020: Accessories for child restraints used in motor vehicles*, provides a framework for the general requirements for a warning device/system to alert a driver to a child occupant being left in a vehicle.

Mark Terrell, Chief Technical Officer, ANCAP Safety

48 ANCAP is an independent vehicle safety consumer advocate. Since 2023, ANCAP has been assessing and rewarding Child Presence Detection (**CPD**) systems as part of their star ratings protocols. This encourages manufacturers to voluntarily fit CPD systems in new cars.

49 Mr Terrell's description of typical features of a CPD system follows.

(1) A vehicle is fitted with one or more internal sensors each able to view one row of the vehicle seating.

(2) More advanced sensors are radar based but can be ultrasonic or use a camera. The former may detect a child covered in a blanket whereas the latter may not.

(3) Additional data may be processed such as opening of doors, seatbelt use (although irrelevant for a fixed car seat) and driving history to determine if there is a potential 'child left' scenario.

(4) The system will initially beep when the car is locked to alert the driver and if no action is taken then additional steps will follow including beeping horns/flashing lights/phone/app messages and in some cases air conditioning will activate or the windows will open.

50 In his evidence, Mr Terrell confirmed that:

(1) digital systems can often easily be turned off, and

(2) it can take 20 years for new car safety initiatives to 'flow through' to all or most road users.

After market devices

51 AN's father also helpfully provided the Assisting team with information regarding multiple reasonably priced aftermarket devices.

52 It was proposed by the Assisting team that I recommend to Kidsafe NSW that they consider including information on their website in relation to available after market child presence detection devices that comply with Standards Australia standards, including AS 8005: 2020.

53 In her letter of 4 May 2026, Ms Erskine indicated that to her knowledge, no after market devices have been certified as compliant with the applicable Australian Standards. However, she is continuing to investigate this issue.

54 Ms Erskine also indicated that Kidsafe are co-ordinating with their colleagues to develop better, more appropriate messaging to inform parents and carers of the impact of memory lapses and the potential tragic consequences of children unintentionally left in vehicles for extended periods of time.

Recommendations

55 On the basis that there appears to be no after-market device that has been certified by Standards Australia as compliant with their standards, including AS 8005: 2020, I am declining to make the proposed recommendation to Kidsafe NSW.

56 However, given Ms Erskine's engagement in this inquest and her letter of 4 May 2026 regarding proposed recommendations, I am confident that on receipt of the findings and transcript, Kidsafe NSW will have regard to the evidence of Professor Irish in the development of strategies for child accident prevention.

57 There appears to be a developing body of research and literature in the USA relating to the potential utility of such devices (both inbuilt and aftermarket) that Australian government and non-government agencies with responsibilities for relevant safety issues would be wise to have regard to in relation to any future regulatory and prevention efforts.[6]

Childcare provider notifications

58 In this case[7] had the parents been notified that AN did not arrive at childcare, this could have acted as a memory prompt, and it is possible that AN could have been retrieved and his death prevented. In saying this, I am in no way critical of the early childcare provider. There was, at that time, no obligation on them to notify parents or carers if a child did not arrive. However, given this case and the case of OVA both arise from a lapse in memory causing the children not to be taken to childcare, it is a relevant issue to consider in the context of potential death prevention.

59 Correspondence from the DoE is included in the brief of evidence. Relevantly, the DoE advised that early childhood education and care (**ECEC**) services in NSW are not obliged to notify carers when a child does not attend an ECEC service.

60 The *Children (Education and Care Services) National Law (NSW) and Education and Care Services National Regulations* establish the national approach to regulation, assessment and quality improvement for most ECEC services in NSW. This national approach is referred to as the National Quality Framework (**NQF**).

---

[6] After the close of evidence, correspondence was received by the Crown Solicitors Office from Mr Terrell, drawing attention to one such (very recent) paper by the US National Highway Traffic Safety Administration (NHTSA), *Status of NHTSA's Research on Unattended Child Reminder Systems*.
[7] As well as in the case of OVA.

61 DoE has confirmed that it is working closely with its Federal Government and State and Territory counterparts and it supports exploring 5 options currently under consideration for ECEC providers:

(1) public awareness campaign

(2) ECEC sector specific communications and engagement activities

(3) identify and implement non-mandatory technology systems options

(4) require child attendance checks and notifications to parents and carers (would require amendments to the National Law/Regulations)

(5) require policies and procedures for child attendance checks and notifications to parents and carers (would require amendments to the National Law/Regulations).

62 However, correspondence received from the Department of Education dated 10 April 2026 advised that following a meeting of Education Ministers on 20 February 2026, 'non-regulatory preventative and responsive measures were more appropriate to the issue at hand'. This approach was endorsed in correspondence received from the Early Learning Commission (**ELC**) and the DoE on receipt of recommendations proposed by the Assisting team.

63 In particular, the following issues were identified as reducing the beneficial impact of mandatory notification:

(1) that fatal heatstroke could occur in minutes in Australia's hot climate such that even if a notification is made it may well be too late to prevent a child fatality, and

(2) that there is generally no fixed time during which a child may be dropped off and so a mandatory notification is unlikely to be sent during the window of time required to prevent death.

64 The ELC submitted that a mandatory notification is not a substitute for immediate preventative measures at the point of risk such as in-vehicle technologies or ‘direct parental vigilance’.

65 As the evidence of Professor Irish indicated, measures to be adopted are seeking to insert memory cues to trigger a response from a parent or carer who may, through fatigue or stress or otherwise, be suffering from a memory lapse. ‘Direct parental vigilance’ will not prevent a memory lapse of this nature and the assertion that it will highlights the general lack of understanding of the risk.

66 The timing of a drop off reminder may not have to be perfect, to act as a cue and prevent a memory lapse. While the window of time may be limited, it would be greater in the colder months.[8]

67 There is no suggestion that mandatory notification is to be the only or even the best tool. However, it is a tool which could have a powerful impact. Preventing one tragedy of this nature would be impactful for the family and the community. There was no evidence before the inquest as to how onerous an obligation to notify would be. However, we are in a digital age where it can be expected that such an obligation could be exercised via automation.

<u>Recommendation</u>

68 In my view the issue of mandatory notification to parents or carers where a child has not arrived at childcare is an issue which should be reconsidered in view of the evidence heard at this inquest.

69 Accordingly, I make the recommendation that follows.

[8] The temperature dependant nature of such events is demonstrated by the US data in evidence, indicating significant numbers of deaths in hotter months and US states, and almost no deaths in cooler months.

I direct that a copy of the brief of evidence, the inquest findings and the hearing transcript be sent to the NSW Minister for Education, the DoE and NSW Early Learning Commission and that they:

(1) consider, in the context of the NQF and having regard to the evidence and findings in this inquest and the inquest into the death of OVA, introducing a system requiring the mandatory notification of a parent or caregiver by childcare services of unexpected absences of children.

Concluding remarks

70 I will close by conveying to AN's family, friends and their community, my sympathy for the tragic loss of AN.

71 I thank the Assisting team for their outstanding support in the conduct of this inquest.

72 I thank the officer in charge, Constable Derek Kennedy, for his work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

73 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity
The person who has died is AN.

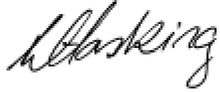
Place of death
AN died in Glenfield, NSW.

Date of death
AN died on 2 February 2023.

Cause of death
AN died from environmental heat exposure due to vehicular entrapment.

Manner of death
AN was unintentionally left in the vehicle because of memory failure.

I close this inquest.



Judge R Hosking
Deputy State Coroner
Lidcombe

****